3 Waiver Services for Adults with Developmental Disabilities, Adults with a Traumatic Brain Injury, and ISSH Waiver Participants

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided through the Waiver Services programs for Adults with Developmental Disabilities (DD Waiver), Adults with a Traumatic Brain Injury (TBI Waiver), and the Idaho State School and Hospital (ISSH Waiver). These programs are provided as deemed appropriate by DHW. This section addresses the following:

- Participant eligibility
- Record keeping
- Payment
- Prior authorization
- Third party recovery
- Claims billing
- Waiver services policy
- Specific waiver services:
  - Adult day care DD, ISSH
  - Assisted non-medical transportation services DD, ISSH
  - Behavior consultation/crisis management services DD,ISSH
  - Chore services DD,ISSH
  - Day habilitation services
  - Environmental modification services DD,ISSH
  - Home-delivered meals services DD,ISSH
  - Nursing services DD,ISSH
  - Personal care services
  - Personal emergency response system services DD,ISSH
  - Residential habilitation services DD,ISSH
  - Respite care services DD,ISSH
  - Specialized medical equipment and supplies services DD,ISSH
  - Supported employment services DD,ISSH

NOTE: DD/TBI/ISSH services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

Each provider service subsection in this handbook describes the service, payment, and diagnosis, place of service and procedure codes for that service.

3.1.2 Participant Eligibility

Idaho Medicaid provides health coverage for qualified adults and children. Medicaid only reimburses for treatment rendered while the participant was

See **Section 1.4** for more on participant eligibility

eligible for Medicaid benefits. Eligibility for the TBI Waiver is defined in the rules governing medical assistance IDAPA 16.03.09 section 766-767. Eligibility for DD Waiver and ISSH Waiver is defined in the rules governing medical assistance IDAPA 16.03.09.143.

3.1.3 Record Keeping

3.1.3.1 Medical Record Contents

DHW requires all providers to meet the documentation requirements listed in the provider enrollment agreement and IDAPA rules. Providers must generate and maintain all records to fully document the extent of services submitted for Medicaid reimbursement.

3.1.3.2 Medical Record Retention

Providers must retain records to document services submitted for Medicaid reimbursement for at least five years after the date of service for auditing purposes.

3.1.4 Payment

Medicaid reimburses DD, ISSH, or TBI Waiver services on a fee-for-service basis. Medicaid may also reimburse TBI Waiver services to an agency based on an individualized daily composite rate. Prior authorization based upon guidelines established by the Department must be obtained prior to billing for waivered services.

See **Section 1.5,** for more on Healthy Connections.

For the DD and ISSH waivers, check eligibility to see if the participant is enrolled in Healthy Connections, Idaho Medicaid's managed care program. If a participant is enrolled, certain guidelines must be followed to ensure reimbursement for providing Medicaid-covered services.

Reimbursement is subject to review to insure that billed services were rendered. The review also determines that the services were provided in accordance with the Medicaid Provider Enrollment Agreement and additional terms waiver provider agreement(s), the rules governing medical assistance, and the requirements of this handbook. Payment of services is subject to recoupment when it is determined that the service was not properly provided.

3.1.5 Prior Authorization

The Regional Medicaid Services (RMS) or designee must prior authorize all services reimbursed by Medicaid under the DD Waiver, ISSH, and TBI Waiver programs before the payment of services. All prior authorization numbers must be included on the claim or the authorized service will be denied.

NOTE: The Bureau of Medicaid Programs and Resource Management DME Section is responsible for the prior authorization of Certified Medical Equipment and Supplies (SME) for the DD/ISSH Waiver.

For Healthy Connections participants on the DD or ISSH waiver, prior authorization will be denied if the requesting provider is not the primary care provider or a referral has not been obtained.

Approved prior authorizations are valid for one year from the date of prior authorization by the RMS Unit unless otherwise indicated. Prior authorization for services authorizes an Idaho Medicaid provider to perform Medicaid covered services for an eligible Medicaid participant but does **not** guarantee payment.

3.1.6 Third Party Recovery

See **General Billing Information, Section 2, Third Party Recovery**, for information regarding DHW policy on billing all other third party resources before submitting claims to Medicaid.

3.1.7 Change of Provider Information

If the provider has a change of name, address, or telephone number, immediately notify the Department in writing. Indicating updated provider information on a claim form is not acceptable.

3.2 Waiver Services Policy

3.2.1 Overview of Policy for Waiver Programs

3.2.1.1 DD Waiver and ISSH Waiver Overview

Waiver Services for Adults with Developmental Disabilities (DD Waiver) and Idaho State School and Hospital Waiver (ISSH Waiver) services are part of the Community Supports for People with Developmental Disabilities Program. Currently, Idaho has two waivers for persons with developmental disabilities:

- A waiver for any individual at least 18 years of age who meets intermediate care facility for the mentally retarded (ICF/MR) level of care requirements
- A waiver for adolescents 15 through the month of their 18 birthday who have lived at ISSH, meet ICF/MR level of care, and have chosen to receive community based services

Services, provider qualifications, record requirements, etc., are the same for both waivers.

For a participant to be eligible for either waiver, the Regional Medicaid Services (RMS) unit or designee must determine that the participant meets **all** of the following criteria:

- Requires services due to a developmental disability that significantly limits mental or physical function or independence in 3 of 7 life skill areas and has been determined to meet the categorical criteria for mental retardation in the state of Idaho or has been determined to have a related condition.
- Is capable of being maintained safely and effectively in a non-institutional setting.
- Would need to reside in an ICF/MR in the absence of such services.

3.2.1.2 TBI Waiver Overview

The Traumatic Brain Injury (TBI) Waiver is based on the belief that persons with brain injury have the right to learn, live, work, and recreate in the community using services and information that will assist them in making informed choices. Services are designed to promote independence, productivity, and inclusion. TBI waiver services will be available in the individual's own home and/or community, and will encourage the involvement of non-paid support involving family, friends, neighbors, volunteers, religious community, and others.

The TBI Waiver is a Medicaid home and community-based waiver that is authorized under 1915(c) of the Social Security Act. There are fourteen (14) core services offered under this waiver.

For a person to be eligible for Medicaid payment of waiver services, the RMS must determine:

- The individual received injury to the brain on or after the age of twenty-two (22).

- The individual would need to reside in a nursing facility (NF) in the absence of such services.
- The individual would be capable of being maintained safely and effectively in a non-institutional setting and has chosen to receive community based services.
- The Medicaid program expenditures for the care of the individual in the community in the aggregate would be no more than the Medicaid program costs for care in a Nursing Facility.
- The individual is determined to need and continue to need waiver services based on the diagnostic criteria found in Table 767 of IDAPA 16.03.09.767. In addition, the need for each service is documented in the results of an assessment. These include:

3.2.1.3 Table 767

Classification	Code Number Classification Description
348.1	Anoxic brain damage
431	Intra cerebral hemorrhage
800-800.90	Fracture of a vault of the skull
801-801.99	Fracture of the base of the skull
803-803.99	Other skull fractures
804-804.99	Multiple fractures involving the skull, face and other bones
850-850.99	Concussion
851-851.99	Cerebral laceration and contusion
852-852.99	Subarachnoid, subdural, and extradural hemorrhage following injury
853-853.99	Other unspecified Intra cerebral hemorrhage following injury
854-854.99	Intracranial injury of other and unspecified nature
905.0-907.0	Late effects of skull and face fractures plus late effects of intracranial injury without fractures.

3.2.2 Place of Service Delivery

Participants may choose to receive DD Waiver, TBI Waiver, or ISSH Waiver services in the following settings, depending on the service. Check the place of service codes for each service under each respective waiver:

12 Home

99 Other place of service (community)

3.2.2.1 Place of Service Exclusions

The following living situations are specifically excluded as a personal residence:

- Licensed, skilled, or intermediate care facility; certified nursing facility (NF); or hospital
- Licensed intermediate care facility for the mentally retarded (ICF/MR)

- Licensed residential and assisted living facility.

3.2.3 Plan of Service

All services must be provided based on a written plan of service. The plan is referred to as the Plan of Care for TBI participants.

3.2.3.1 Plan Development

The Person-Centered Planning team includes:

- The participant
- The plan developer, and/or service coordinator, if chosen, by the participant for DD/ISSH Waiver
- The guardian, family, or current service providers, unless specifically excluded by the participant
- Others identified by the participant
- For TBI participants, the Department's Administrative Case Manager from the Regional Medicaid Services Unit

The plan is based on a person-centered, DHW-approved planning and assessment process. It describes the specific types, amounts, frequency, and duration of Medicaid-reimbursed services to be provided. It lists all support and service needs to be met by the participant's family, friends, other community resources, and the providers of services, when known.

The plan of service must include documentation of the participant's choice between waiver services and institutional placement, the participant's or a legal guardian's signature (if applicable), and the signature of either the service coordinator for the participant or the Department's Administrative Case Manager for TBI Waiver participants.

At least annually, the plan must be revised, updated, and services authorized based upon changes in the participant's needs.

3.2.3.2 Service Supervision

The plan includes all Medicaid allowable services and supports, and all natural or non-paid services and supports. See Idaho Administrative Procedures Act (IDAPA), section 16.03.09.143 for supervision requirements for each service for DD and ISSH Waivers. See Sections 16.03.09.768 through 793 for description of services for the TBI Waiver.

3.2.4 Provider Qualifications

All providers of services must meet qualifications as outlined in IDAPA rules section 16.03.143.05 for DD/ISSH Waiver and 16.03.09.796 for TBI Waiver. The RMS unit monitors performance under provider agreements for all waiver service providers.

All TBI Waiver services must be provided by an agency provider with the following exception. Residential habilitation providers who are unable to be employed by an agency because one is not available in their geographic area must receive program development, implementation, and oversight of service delivery by a Program Coordinator who has a valid case management, service coordination, or targeted service coordination provider

agreement with the Department and who has taken a traumatic brain injury training course approved by the Department.

3.2.5 Important Billing Instructions

Dates of service must be within the Sunday through Saturday calendar week on a single detail line on the claim. The calendar week begins at 12:00 a.m. on Sunday and ends at 11:59 p.m. on Saturday. Failure to comply with the Sunday through Saturday billing will result in claims being denied. In addition, one detail line on a DD, ISSH, or TBI waiver claim form cannot span more than one calendar month. If the end of the month falls in the middle of a week two separate detail lines must be used.

Example: August 2001 Billing

The last week in August 2001, begins Sunday, August 26, 2001, and ends Saturday, September 1, 2001. Two separate detail lines must be entered on the claim form for this week. One detail line will have service dates of 08/26/2001 through 08/31/2001. The second detail line will have service dates of 09/01/2001 through 09/01/2001. Consecutive dates of service that fall in one calendar week (Sunday through Saturday) can be billed on one claim detail line as long as the same quantity of services have been provided each day.

Sun	Mon	Tues	Wed	Thurs	Fri	Sat
			August 1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	**Sept. 1**

3.2.6 Adult DD Care Management

October 1, 2003, the Division of Medicaid implemented Care Management for Adults with Developmental Disabilities with a new chapter of rules, IDAPA 16.03.13 – "Prior Authorization for Behavioral Health Services". The new rules cover prior authorization for all adult Developmental Disability (DD) program services including DD waiver, DDA services, and service coordination. They also cover prior authorization of services provided to adolescents age 15 through the month of the 18th birthday eligible for the ISSH waiver. Services included in the new business model are discussed in more detail below.

3.2.7 Community Crisis Supports

Community Crisis Support is a service available to Adults with Developmental Disabilities beginning October 20, 2003.

Community Crisis Supports includes intervention for participants in crisis situations to ensure their health and safety or prevent hospitalization or incarceration of a participant. Community Crisis Support may include:

- Loss of housing, employment, or reduction of income
- Risk of incarceration
- Risk of physical harm

- Family altercation or other emergencies defined by the participant

Community Crisis Support is the choice of the participant and may be billed by Service Coordinators, Plan Developers (must meet service coordinator qualifications as described in 16.03.17), Plan Monitors, Developmental Disability Agencies, and all DD and ISSH Waiver providers **except:**

- Specialized Medical Equipment Agencies
- Non-Medical Transportation Providers
- Personal Emergency Response Agencies
- Home Delivered Meal Providers

Community Crisis Supports is limited to a maximum of 20 hours per crisis for a period of five (5) consecutive days. Services may not exceed 20 hours per crisis.

The Regional Care Manager will review and authorize each crisis service to make determination for appropriateness and financial reimbursement. Providers must get either a written or verbal approval for Community Crisis Supports prior to billing.

Providers must identify on the Crisis Authorization Worksheet the factors contributing to the crisis and develop a proactive strategy that will address the factors that result in crisis.

3.2.8 Medical Care Evaluation for Assessment

The Care Management Program includes an assessment process which includes the requirement for a History and Physical Examination and referral from the physician (the participant's Healthy Connections provider, if applicable) for adults with developmental disabilities.

History and physicals for adults will be reimbursed by Medicaid when it is a Medicaid program requirement. When billing for history and physical exams for developmentally disabled adults that have been requested by the Medicaid program, use the following CPT codes:

- **99450** for history and physical examinations to complete the Medical Care Evaluation form
- **99080** for completion of the Medical Care Evaluation form from a record review

Use the diagnosis code **V70.3** (Other medical examination for administrative purposes)

3.2.9 Plan Development

Plan Development is allows for hourly payment for plan development. This service must be provided by a Service Coordinator. The plan developer is chosen by the participant and may be reimbursed for participation in the budget negotiation meeting, facilitating the person-centered planning meeting, writing the plan of service, and any subsequent plan addendums.

G9007 Plan Development must be prior authorized and is billed in 15 minute unit increments with the limitation of 48 units (12 hours) per calendar year.

3.2.10 Plan Monitoring

Plan monitoring allows for hourly payment for monitoring of the plan when the participant **does not** have a Service Coordinator. Plan monitors are chosen by the participant. They must monitor the plan at least every 30, 60, or 90 days as identified on the plan of service. Plan monitoring is limited to 8 hours per year.

Plan monitoring must include all of the following:

- review of the plan of service in a face-to-face contact with the participant to identify current status of programs and changes if needed
- contact with service providers to identify barriers to service provision
- discussion with the participant about satisfaction regarding quality and quantity of service
- provider status reviews and completion of plan monitor summary when the plan has been effect for 6 months and at the annual plan.

3.2.11 Procedure Codes

Use the five-digit HCPCS procedure code. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	HCPCS Code	Description
Community Crisis Supports	H2011	Intervention for participant in crisis situations. (See Information Release 2003-89). Service is limited to a maximum of 20 hours per crisis for 5 consecutive days. Service may not exceed 20 hours per crisis.
Medical Care Evaluation – History & Physical Examinations	99450	History and physical examinations to complete the Medical Care Evaluation form. Use diagnosis code **V70.3** (Other medical examination for administrative purposes).
Medical Care Evaluation – Completion of Evaluation from Record Review	99080	Completion of the Medical Care Evaluation form from a record review Use diagnosis code **V70.3** (Other medical examination for administrative purposes).
Plan Development	G9007	Plan Development. Effective for dates of service on or after 11/01/03. Limited to 12 hours per year. 1 unit = 15 minutes Prior authorization required.
Plan Monitoring	G9012	Plan Monitoring. Must occur at least every 30, 60, or 90 days as identified on the plan of service. Limited to 8 hours per year. 1 unit = 15 minutes Prior authorization required.

3.3 Adult Day Care Services

3.3.1 Service Description for DD and ISSH waivers

Adult day care for adults with developmental disabilities is a structured day program, outside the home of the participant that offers one or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. These activities need to be identified on the Plan of Service.

3.3.2 Provider Qualifications

All providers of this service when delivered in a DDA must be employed by an agency.

Adult Day Care may be provided by one of the following:

- Developmental Disability Agency
- Nursing Facility
- Licensed Residential Facility
- Assisted Living Facility
- Certified Family Home (affiliated with a Residential Habilitation Agency)
- Residential Habilitation Agency

Providers of Adult Day Care who are not one of the above must meet the fire/life safety requirements of a certified family home or Developmental Disability Agency.

Providers of Adult Day Care must:

- Demonstrate the ability to communicate and deal effectively, assertively and cooperatively with a variety of people
- Be a high school graduate or have a GED or demonstrate the ability to provide services according to the Plan of Service
- Be free of communicable disease
- Pass a criminal history check
- Demonstrate knowledge of infection control methods
- Agree to practice confidentiality in handling situations that involve waiver participants
- And any other requirements identified in the Medicaid Provider Agreement.

3.3.3 Service locations

Adult Day care may be provided in the following locations:

Home: Adult Day Care services provided in a home environment other than the participant's primary residence, must meet the standards for home certification identified in the *Rules Governing*

Certified Family Homes, IDAPA 16.03.19, and health standards identified in the *Rules Governing Developmental Disabilities Agencies*, IDAPA 16.04.11.921.

Facility: Day Care services provided in a facility must meet building and health standards identified in the *Rules Governing* Developmental Disabilities Agencies, IDAPA 16.04.11.920-921.

3.3.4 Payment

Medicaid reimburses waiver services on a fee-for-service basis. All Adult Day Care must be prior authorized by the Department or its designee before being rendered and must be the most cost effective way to meet the needs of the participant.

Adult Day Care cannot exceed 30 hours per week either billed alone or in combination with developmental therapy, occupational therapy, or Intensive Behavioral Intervention.

3.3.5 Diagnosis codes

Enter the appropriate ICD-9-CM code for the primary diagnosis in field 21 on the CMS 1500 claim form or in the appropriate field of the electronic claim.

3.3.6 Place of Service Codes

Adult Day Care services can only be provided in the following places of service:

12 – Home (Certified Family Home)

99 – Community (DDA)

Enter this information in field 24 B on the CMS 1500 claim form or in the appropriate field on the electronic claim.

3.3.7 Procedure Code

Use the following five-digit HCPCS procedure code with the required modifier for all Adult Day Care. Enter this information in field 24 D on the CMS 1500 claim form or in the appropriate field on electronic billing software.

Service	HCPCS Code	Description
DD/ISSH Waiver		
Adult Day Care	S5100 U8 Modifier Required	*Day Care Services, adult; per 15 minutes.* The limit of hours for Adult Day Care is 30 hours per week billed alone or in combination with Developmental Therapy, Occupational Therapy or IBI.

3.4 Assisted Non-Medical Transportation Services

3.4.1 Service Description for DD Waiver, ISSH Waiver, and TBI Waiver

Assisted transportation services are non-medical transportation services used by a participant to access community services and other waiver or waiver-related services required by the plan of service. This service is in addition to medical transportation services and does not replace them. Waiver transportation is limited to 1800 miles per year.

Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized.

3.4.2 Provider Qualifications

Providers of assisted transportation services must possess a valid driver's license, valid vehicle insurance, comply with all applicable state laws, and be enrolled as a Medicaid transportation provider. Waiver transportation may be provided by either an agency or an individual provider.

3.4.3 Payment

Payment for Non-Medical Waiver transportation is reimbursed at the per-mile rate established by Medicaid. Participants receive a prior authorization notice that identifies the procedure codes that have been approved and are to be used for billing.

3.4.4 Diagnosis Codes

Enter the ICD-9-CM code **V604** - "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim.

3.4.5 Place of Service Code

Non-medical transportation can only be provided in the following place of service:

99 – Other place of service (Community)

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim.

3.4.6 Procedure Codes

Use the five-digit HCPCS procedure code with the required modifier when billing non-medical transportation services. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	HCPCS Code	Description
TBI Non-Medical Transportation	A0080 U3 Modifier Required	*Non-emergency transportation, per mile-vehicle provided by volunteer (individual or organization), with no vested interest.* **Note: This service may be provided by an agency or individual transportation provider and is paid at two different rates.**
DD/ISSH Non-Medical Transportation	A0080 U8 Modifier Required	*Non-emergency transportation, per mile-vehicle provided by volunteer (individual or organization), with no vested interest.* **Note: This service may be provided by an agency or individual transportation provider and is paid at two different rates.**

3.5 Behavior Consultation/Crisis Management Services

3.5.1 Service Description for DD Waiver, ISSH Waiver, and TBI Waiver

Behavior consultation and crisis management (BC/CM) services are services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development to providers related to the needs of a participant. This service requires the provider to meet directly with the participant.

3.5.2 Provider Qualifications

3.5.2.1 Behavior Consultation and Crisis Management Providers

DD Waiver, ISSH Waiver, and TBI Waiver providers of this service must work in one of the following situations:

In a provider agency capable of supervising the direct service or.

Under the direct supervision of a licensed psychologist or Ph.D. in special education with training and experience in treating severe behavioral problems, and training and experience in applied behavioral analysis.

DD Waiver and ISSH Waiver providers must have or be one of the following:

- Have a Master's degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study.
- Be a licensed pharmacist.
- Be a qualified mental retardation professional (QMRP).

TBI Waiver providers must have or be one of the following:

- Have a Master's degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study, or
- Be a licensed pharmacist, and
- Have taken a traumatic brain injury training course approved by the Department.

3.5.2.2 Emergency Intervention Technicians

Emergency intervention technicians for the ISSH/DD Waiver must:

- Meet qualifications of a Residential Habilitation direct care provider as identified in the *Rules Governing Residential Habilitation Agencies*, IDAPA 16.04.17.
- Have at least one year of experience working directly with adults with developmental disabilities who exhibit severe maladaptive behaviors that may cause harm to themselves or others.
- Be supervised by a QMRP or clinician.
- Emergency intervention technicians for the TBI Waiver must:
- Meet qualifications of a Residential Habilitation direct care provider
- Have at least one year of experience working directly with adults with a traumatic brain injury.
- Be supervised by a clinician.

3.5.3 Payment

Medicaid reimburses behavior consultation/crisis management services on a fee-for-service basis. All services must be authorized prior to payment and must be the most cost-effective way to meet the needs of the participant. The Department or its designee authorizes all services for the DD and ISSH waivers. The RMS authorizes TBI services. The prior authorization number must appear on the claim or the claim will be denied.

3.5.4 Diagnosis Codes

Enter the ICD–9-CM code V604-"No other household member able to render care" for the primary diagnosis in field 21 on the CMS 1500 claim form or the appropriate field on an electronic claim.

3.5.5 Place of Service Codes

Behavior consultation/crisis management services can only be billed for the following places of service:

11 — Office

12 — Home

99 — Other place of service (Community)

Enter this information in field 24B on the CMS 1500 claim form or in the appropriate field on an electronic claim.

3.5.6 Procedure Codes

All behavior consultation/crisis claims must use one of the following five-digit HCPCS or CPT procedure codes with the required modifier when billing. The units must be entered in field 24D on the CMS 1500 claim form or the appropriate field on an electronic claim.

Service	HCPCS Code	Description
DD/ISSH Waiver		
Psychiatric Consultation	H2019 U8 Modifier Required U1 Modifier Required when provided by physician	*Therapeutic Behavioral Services* 1 unit = 15 minutes
Behavior Consultation/Crisis Management — QMRP	H2019 U8 Modifier Required	*Therapeutic Behavioral Services* 1 unit = 15 minutes
Emergency Intervention Technician	H2019 U8 and HM Modifier Required	*Therapeutic Behavioral Services* Limited to 96 units per calendar month. 1 unit = 15 minutes

Service	HCPCS or CPT Code	Description
TBI Waiver		
Emergency Intervention Technician	H2011 U3 Modifier Required	*Crisis Intervention Service, per 15 minutes* 1 unit = 15 minutes
Professional Behavior Consultation	90899 U3 Modifier Required	*Unlisted psychiatric service or procedure* 1 unit = 15 minutes

3.6 Chore Services

3.6.1 Service Description for DD Waiver, ISSH Waiver, and TBI Waiver

Chore services include heavy household maintenance and minor home repairs necessary to maintain the functional use of the home and to provide a clean, sanitary, and safe environment. This service is limited to services provided in a home rented or owned by the participant.

Chore activities include, but are not limited to:

- Washing windows and walls
- Moving heavy furniture
- Shoveling snow to provide safe access outside the home
- Chopping wood when wood is the participant's primary source of heat
- Tacking down loose rugs and flooring
- Professional electrical or plumbing services

These services are only available when neither the participant, nor anyone else in the household, is capable of performing or financially providing for these services. This includes when no other relative, caretaker, landlord, community volunteer/agency, or third party payer is capable of or responsible for their provision.

In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

3.6.2 Provider Qualifications

Providers of chore services must be skilled in the type of service to be provided and demonstrate the ability to provide services according to the plan.

3.6.3 Provider Responsibilities

3.6.3.1 Chore Services — Skilled

Skilled chore services require a provider to have a license or other certification to perform services such as electrical work and plumbing. These services require three written bids for the cost of the service up to $1500.00. If the cost of the service is over $1500.00, see **Section 3.6.4, Payment**.

3.6.3.2 Chore Services – Unskilled

Unskilled chore services are those routine activities including, but not limited to, washing windows, shoveling snow, or chopping wood. No certification or license is required to perform these services.

3.6.4 Payment

Medicaid reimburses waiver services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid allowance. All chore services

must be authorized by the RMS or Department designee before payment and must be the most cost-effective way to meet the needs of the participant.

The rates will be either the cost of the service up to $1500 or the lowest of three written bids if the cost exceeds $1500 or no more than $8.00 per hour.

3.6.5 Diagnosis Codes

Enter the ICD-9-CM code V604- "No other household member able to render care", for the primary diagnosis in field 21 on the CMS 1500 claim form or the appropriate field of the electronic claim.

3.6.6 Place of Service Code

Chore services can only be provided in and billed with the following place of service:

12 — Home

Enter this information in field 24B on the CMS 1500 claim form or in the appropriate field of the electronic claim.

3.6.7 Procedure Codes

Use one of the following five-digit HCPCS procedure codes for all chore service claims. Enter this information in field 24D on the CMS 1500 claim form or in the appropriate field on electronic billing software.

Service	HCPCS Code	Description
DD/ISSH Waiver		
Chore Services – Skilled	S5121 U8 Modifier Required	*Chore Services, per diem* 1 unit = 1 service Cost of service up to $1500.00 or lowest of 3 bids. Not to exceed $8.00 per hour. NOTE: The previous code for unskilled chore services - 0270B - was ended on 10/20/03.

Service	HCPCS Code	Description
TBI Waiver		
Chore Services – Skilled	S5121 U3 Modifier Required	*Chore Services, per diem* 1 unit = 1 service Cost of service up to $1500.00 or lowest of 3 bids
Chore Services - Unskilled	S5120 U3 Modifier Required	*Chore Services; per 15 minute unit*. Not to exceed $8.00 per hour.

3.7 Day Rehabilitation Services

3.7.1 Service Description (For TBI Waiver Only)

Day rehabilitation for adults with a traumatic brain injury consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Day rehabilitation takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week unless provided as an adjunct to other day activities included in a participant's Plan of Care. There is a limitation of 30 hours per week.

Day rehabilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the Plan of Care. In addition, day rehabilitation services may serve to reinforce skills or lessons taught in employment, therapy, or other settings.

3.7.2 Provider Qualifications

All providers of service must have a valid provider agreement with DHW. The RMS in each region will monitor performance under this agreement. Day rehabilitation providers must have:

A minimum of two (2) years of experience working directly with persons with a traumatic brain injury

Provide documentation of standard licensing specific to their discipline

Have taken a traumatic brain injury training course approved by the Department.

3.7.3 Payment

Medicaid reimburses waiver services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid allowance. All day rehabilitation services must be prior authorized by the RMS before being rendered and must be the most cost-effective way to meet the needs of the participant. Prior authorization numbers MUST appear on the claim or the service will be denied.

3.7.4 Diagnosis Codes

Enter the appropriate ICD-9-CM code for the primary diagnosis in field 21 on the CMS 1500 claim form or in the appropriate field of the electronic claim.

3.7.5 Place of Service Codes

Day rehabilitation services can only be provided in the following places of service:

11 — Office

99 — Other place of service (Community)

Enter this information in field 24B on the CMS 1500 claim form or in the appropriate field of the electronic claim.

3.7.6 Procedure Codes

Use one of the following five-digit HCPCS procedure codes and required modifier for all day rehabilitation services. Enter this information in field 24D on the CMS 1500 claim form or in the appropriate field on electronic billing software.

Service	HCPCS Code	Description
TBI Waiver		
Day Rehabilitation (Individual)	T2021 U3 Modifier Required	*Day Habilitation, waiver; per 15 minutes* The limit of hours for day rehab is 30hrs/wk for both individual and group or in combination 1 unit = 15 minutes
Day Rehabilitation (Group) limited to not more than six participants	T2021 U3 and HQ Modifiers Required	*Day Habilitation, waiver; per 15 minutes* 1 unit = 15 minutes

3.8 Environmental Accessibility Adaptations (Modifications) Services

3.8.1 Service Description For DD Waiver, ISSH Waiver, and TBI Waiver

Environmental Modifications (Accessibility Adaptations) are interior or exterior physical adaptations to the home owned or rented by the participant, identified on the participant's ISP, and necessary to ensure the health, welfare, and safety of the individual. The modifications enable the participant to function with greater independence in the home and, without which, the participant would require institutionalization. This service is not available to CFH owners.

Note: Provider responsibilities, payment information, and diagnosis, place of service and procedure codes can be found in Section 3 of the *Idaho Medicaid Provider Handbook* for Medical Vendor providers.

Such adaptations may include:

- Installation of ramps and lifts
- Widening of doorways
- Modification of bathroom and kitchen facilities
- Installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant

3.8.2 Provider Qualifications

All providers of service must have a valid provider agreement with DHW. The RMS Unit monitors performance under this agreement in each region. Environmental modification providers must:

- Demonstrate the skills necessary to provide the service identified on the plan.
- Be approved by the RMS or Department designee.

Environmental Modifications (Accessibility Adaptations) services must comply with requirements and permits of the city, county, or state in which the modifications are made. The provider must demonstrate that all modifications, improvements, or repairs will be made in accordance with local and state housing and building codes.

3.8.3 Procedure Codes

Service	HCPCS Code	Description
Environmental Accessibility Adaptations (Environmental Modifications) For TBI Waiver	S5165 U3 Modifier Required	*Home Modifications; per service* Actual cost of 3 competitive bids for items over $500.00 including labor
Environmental Accessibility Adaptations (Environmental Modifications) For DD/ISSH Waiver	S5165 U8 Modifier Required	*Home Modifications; per service* Actual cost of 3 competitive bids for items over $500.00 including labor

3.9 Expanded Therapy Services - TBI Waiver Only

3.9.1 Service Description

Expanded therapy services are available to individuals on the TBI waiver whose medical needs exceed Medicaid program limitations for the following services:

- Occupational therapy
- Speech therapy
- Physical therapy

3.9.2 Provider Qualifications

Providers of services must have a valid provider agreement to provide the services under the state plan by DHW (Developmental Disabilities agencies, independent physical therapists, and outpatient hospitals). Occupational and speech therapy must be provided by an agency capable of supervising the direct service.

Physical therapy services must be provided directly by a licensed physical therapist. Aides may assist with the physical therapy services only when a licensed physical therapist is present.

Occupational therapy may only be performed by a registered occupational therapist, as certified by the National Board of Occupational Therapists.

Speech therapy may only be provided by a therapist who possesses a certificate of clinical competency from the American Speech, Hearing, and Language Association (ASHA) or a therapist who is eligible for ASHA certification within one year of employment.

Through the TBI Waiver program, therapy services include:

- Services exceeding Medicaid program limitations
- Consultation with other providers and family members
- Participation on the participant's individual support plan (ISP) team

3.9.3 Payment

Medicaid reimburses TBI Waiver services on a fee-for-service basis. Providers are required to bill their usual and customary fees charged to the general public.

3.9.4 Diagnosis Codes

Enter the ICD-9-CM code V604- "No household member able to render care" for the primary diagnosis in field 21 on the CMS 1500 claim form or in the appropriate field of the electronic claim.

3.9.5 Place of Service Codes

Expanded therapy services can only be billed for the following places of service:

11 — Office (physical therapist, DD DDA)

12 — Home

22 — Outpatient Hospital

99 — Other place of service (Community)

Enter this information in field 24B on the CMS 1500 claim form or in the appropriate field of the electronic claim.

3.9.6 Procedure Codes

Use one of the following five-digit CPT procedure codes for all expanded therapy service claims. Enter this information in field 24D on the CMS 1500 claim form or in the appropriate field on electronic billing software.

3.9.6.1 TBI Waiver

Service	CPT Code	Description
TBI Waiver		
Expanded Physical Therapy; Individual	97110 U3 Modifier Required	*Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility*. This code should be used when the participant has exceeded the allowable maximum services (100 units) covered in the State Plan. Provider may bill for consultations and participation on client's Plan of Care team prior to exceeding limits. 1 unit = 15 minutes
Expanded Physical Therapy; Group	97110 U3 and HQ Modifiers Required	*Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility*. This code should be used when the participant has exceeded the allowable maximum services (100 units) covered in the State Plan. Provider may bill for consultations and participation on client's Plan of Care team prior to exceeding limits. 1 unit = 15 minutes
Expanded Speech Therapy; Individual	92507 U3 Modifier Required	*Treatment of speech language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual.* 1 unit = 15 minutes

Service	CPT Code	Description
Expanded Speech Therapy, Group	92508 U3 Modifier Required	*Treatment of speech language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group, two or more individuals* These codes should be used when the participant has exceeded the allowable maximum services (250 sessions) covered in the Medicaid program. Provider may bill for consultations and participation on client's Plan of Care team prior to exceeding limits. 1 unit = 15 minutes
Expanded Occupational Therapy - Individual	97535 U3 Modifier Required	*Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes.* 1 unit = 15 minutes
Expanded Occupational Therapy – Group	97535 U3 and HQ Modifiers Required	*Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes.* 1 unit = 15 minutes

3.10 Home Delivered Meal Services

3.10.1 Service Description For DD Waiver, ISSH Waiver, and TBI Waiver

Home delivered meals are designed to promote adequate nutrition through the provision and home delivery of one to two meals per day. Home delivered meals are limited to participants who:

Rent or own their own home.

Are alone for significant parts of the day.

Have no regular service providers for extended periods.

Are unable to prepare a balanced meal.

3.10.2 Provider Qualifications

Services of home delivered meals under this section may only be provided by an agency capable of supervising the direct service and must meet the following requirements:

- Ensure that each meal meets one third of the Recommended Daily Allowance as defined by the Food and Nutrition Board of National Research Council of the National Academy of Sciences.
- Maintain registered dietitian documented review and approval of all menus, menu cycles, and any changes or substitutions.
- Ensure that the meals are delivered on time.
- Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest USDA Grade for each specific food served.
- Provide documentation of current driver's license for each driver.
- Be licensed and inspected as a food establishment by the district health department.
- Deliver the meals in accordance with the plan for services in a sanitary manner and at the correct temperature for the specific type of food.

3.10.3 Payment

Medicaid reimburses DD, TBI, and ISSH Waiver services on a fee-for-service basis.

3.10.4 Diagnosis Codes

Enter the ICD-9-CM code V604- "No household member able to render care" for the primary diagnosis in field 21 on the CMS 1500 claim form or in the appropriate field of the electronic claim.

3.10.5 Place of Service Code

Home delivered meals services can only be billed in the following place of service:

12 — Home

Enter this information in field 24B on the CMS 1500 claim form or in the appropriate field of the electronic claim.

3.10.6 Procedure Codes

Use one of the following five-digit HCPCS procedure codes for all home delivered meal service claims. Enter this information in field 24D on the CMS 1500 claim form or in the appropriate field on electronic billing software.

Service	HCPCS Code	Description
DD/ISSH Waivers		
Home Delivered Meals (DD/ISSH)	S5170 U8 Modifier Required	*Home Delivered Meals, including preparation; per meal* This service is restricted to 14 meals per week. No more than 2 meals per day are allowed.
TBI Waiver		
Home Delivered Meals (TBI Waiver)	S5170 U3 Modifier Required	*Home Delivered Meals, including preparation; per meal* This service is restricted to 14 meals per week. No more than 2 meals per day are allowed.

3.11 Nursing Services

3.11.1 Service Description For DD Waiver, ISSH Waiver, and TBI Waiver

Nursing services include nursing oversight and skilled nursing services. The RMS or Department designee must prior authorize all nursing oversight and skilled nursing services for DD or ISSH Waiver and TBI Waiver participants before service delivery. The authorization will indicate the hours of service per day and the number of days per week, or visits per month. Nursing services guidelines are available through the RMS.

3.11.1.1 Skilled Nursing Services

Skilled nursing services include the provision of hands-on nursing services or treatments to eligible participants who need skilled nursing services. The medical needs of the participant must be of such a technical nature that the Idaho Nursing Practices Act requires a licensed nurse to provide the services. Nursing services provided by a licensed practical nurse (LPN) may require oversight by a licensed professional nurse (RN). Such services include but are not limited to the following:

Nasal Gastric Tubes — NG tubes include the insertion and maintenance of NG tubes and participant feeding activities with or without the use of a feeding pump. An RN or LPN must perform this service.

Volume Ventilators — The maintenance of volume ventilators includes associated tracheotomy care when necessary. An RN or LPN must perform this service.

Intravenous Therapy/Parenteral Nutrition — Maintenance and monitoring of an IV site and administration of IV fluids and nutritional materials that require extended time periods to administer. An RN or LPN must perform this service.

Tracheotomy and Oral/Pharyngeal Suctioning — Sterile suctioning and cleansing of the participant's airway and removal of excess secretions from the mouth, throat and trachea. **Only** an RN may perform this service.

3.11.2 Provider Qualifications

Nursing services may only be provided by an RN or LPN. Nursing service providers must have a signed provider agreement on file with the Idaho Medicaid Program. Nursing oversight services may only be provided by an RN. Only agency-employed nurses can provide TBI waiver nursing services.

3.11.3 Provider Responsibilities

- Evaluate changes of condition.
- Notify the physician and plan monitor immediately of any significant changes in the participant's physical condition or response to the service delivery.
- Provide services in accordance with the nursing plan of care and the waiver plan of service.

- Maintain records of care given to include the date, time of start and end of service delivery, and comments on participant's response to services delivered.
- In the case of an LPN, skilled nursing providers, and other non-licensed direct care providers, document that oversight of services by a RN is in accordance with the Idaho Nurse Practice Act and the Rules, Regulations, and Policies of the Idaho Board of Nursing.
- An RN can provide either oversight or skilled nursing services.

3.11.3.1 Nursing Plan of Care

All nursing oversight and skilled nursing services provided must be on a nursing plan of care. The nurse is responsible for the nursing plan of care based upon:

- The nurse's assessment and observation of the participant
- The orders of the participant's physician
- The ISP
- Information elicited from the participant

The nursing plan of care must include all aspects of the medical care necessary to be performed, including the amount, type and frequency of such services. Certain services can be delegated by an RN. When nursing services are delegated to a non-licensed RES/HAB provider, the type, amount of supervision, and training to be provided must be included in the plan.

3.11.3.2 Nursing Plan of Care Update

The nursing plan of care must be revised and updated based upon treatment results or as necessary to meet the participant's changing medical needs, but at least annually. A copy of the plan must remain in the participant's home.

3.11.3.3 Record Keeping

Service records must be maintained on each participant receiving nursing services for a period of 5 years. The record must be maintained in the participant's home. After every visit the provider will enter, at a minimum:

- The date and time of visit. The date is given in MMDDCCYY format:
  Examples:
  02/10/2005; 8:00 a.m. – 11:15 a.m.
  11/24/2005; 10:30 a.m. – 3:15 p.m.
- The length of visit in decimal form.
  Example: a visit of three hours and 15 minutes is entered as 3.25 hours
- The services, supervised or skilled observation provided during the visit
- A statement of the participant's response to the services including any changes noted in the participant's condition

- Any changes in the plan of care authorized by the ISP as a result of changes in the participant's condition
- Signature of the individual providing services, including their professional designation

3.11.4 Payment

Medicaid reimburses DD, TBI, and ISSH Waiver services on a fee-for-services basis.

3.11.5 Diagnosis Codes

Enter the appropriate ICD-9-CM code for the primary diagnosis in field 21 of the CMS 1500 claim form.

3.11.6 Place of Service Codes

Nurse oversight and skilled nursing services can only be billed for the following places of service:

11 — Office

12 — Home

99 — Other place of service (Community)

Enter this information in field 24B on the CMS 1500 claim form or in the appropriate field of the electronic claim.

3.11.7 Procedure Codes

All claims must use one of the following five-digit HCPCS procedure codes when billing nurse oversight and private duty nursing services. Enter this information in field 24D on the CMS 1500 claim form or in the appropriate field of the electronic claim.

3.11.7.1 DD/ISSH Waiver

Service	HCPCS Code	Description
DD/ISSH Waiver		
Nursing Oversight — Independent RN Visit	T1001 U8 and TD Modifier Required	*Nursing Assessment/Evaluation* 1 unit = 1 visit
Nursing Oversight — Agency RN Visit	T1001 U8 and TD Modifier Required	*Nursing Assessment/Evaluation* 1 unit = 1 visit
Private Duty Skilled Nursing – RN - Independent	T1000 U8 Modifier Required	*Private Duty/Independent Nursing Services – Licensed* 1 unit = 15 minutes
Private Duty Skilled Nursing – LPN - Agency	T1000 U8 and TE Modifiers Required	*Private Duty/Independent Nursing Services – Licensed* 1 unit = 15 minutes

Service	HCPCS Code	Description
Private Duty Skilled Nursing – RN - Agency	T1000 U8 and TD Modifiers Required	*Private Duty/Independent Nursing – Licensed* 1 unit = 15 minutes
RN Oversight of LPN Visits	T1001 U8 Modifier Required	*Nursing Assessment/Evaluation* 1 unit = 1 visit

3.11.7.2 TBI Waiver

Service	HCPCS Code	Description
TBI Waiver		
Private Duty Nursing Services – RN - Agency	T1000 U3 and TD Modifiers Required	*Private Duty/Independent Nursing Service – Licensed* 1 unit = 15 minutes
Private Duty Nursing Services – LPN - Agency	T1000 U3 and TE Modifiers Required	*Private Duty/Independent Nursing Service – Licensed* 1 unit = 15 minutes
Private Duty Nursing Services, RN oversight, agency	T1001 U3 and TD Modifiers Required	*Nursing Assessment/Evaluation* 1 unit = 1 visit

3.12 Personal Care Services (PCS)

3.12.1 Service Description for TBI Waiver

Personal Care Services (PCS) under the TBI waiver consist of service exceeding 16 hours per week. Services up to 16 hours per week are covered by the Idaho State Medicaid Plan and do not require the participant to meet level of care and cost effectiveness. However, PCS State Plan services must be medically necessary and meet other program requirements found in IDAPA 16.03.09.146, the *Rules Governing the Medical Assistance Program.*

PCS services must be physician ordered, supervised by a registered nurse, and provided in accordance with a plan of care. The PCS Plan of Care is used by the PCS provider and is a separate document from the Waiver Plan of Care.

3.12.2 Provider Responsibilities

The personal care services (PCS) provider is responsible for medically oriented tasks related to a participant's physical care provided in the participant's personal residence. Such services include, but are not limited to, the following:

- Personal Hygiene - The PCS provider assists the participant with or performs basic personal care and grooming that may include bathing, hair care, assistance with clothing and dressing, bathroom assistance, and basic skin care. The PCS provider may assist the participant with bladder or bowel requirements, which may include helping the participant to and from the bathroom or assisting the participant with bedpan routines.
- Medications - The PCS provider may assist the participant with physician ordered medications that are ordinarily self-administered.
- Meal Preparation - The PCS provider may assist with food, nutrition, and diet activities including meal preparation if the physician determines the participant has a medical need for such assistance. Gastrostomy tube feedings may be performed if ordered by a physician and supervised by an RN if the supervising nurse has properly trained the provider. PCS providers are not authorized to perform nasogastric tube feedings.
- Household Services - The PCS provider may perform such incidental household services the physician determines to be essential to a participant's comfort, safety, and health. Those services include:
- Changing of bed linens for the participant
- Rearranging of furniture to enable the participant to move about more easily
- Doing laundry for the participant
- Cleaning of areas used by the participant when required for the participant's treatment
- Accompanying the participant to clinics, physician's office, or other medical appointments

NOTE: PCS providers may not bring children into a participant's home when providing services.

- Shopping for groceries or other household items required specifically for the health and maintenance of the participant

3.12.2.1 Exclusions

Under no circumstance is the PCS provider authorized to perform any of the following:

- Irrigation or suctioning of any body cavities which require sterile procedures
- Application of sterile dressings
- Administration of prescription medication including injections of fluids into the veins, muscles, or skin
- Procedures requiring aseptic technique
- Skin care which requires sterile technique
- Insertion or irrigation of catheters
- Cooking, cleaning, or laundry for any other occupant of the participant's residence

3.12.2.2 Record Keeping

A personal care service record (progress notes) must be maintained for each participant receiving services. A copy of the record must be maintained in the participant's home, unless another site is authorized by the RMS. The provider must keep the original record for his/her records. Do **not** attach the white copy of progress notes to claims submitted to EDS.

After every visit, the provider will enter, at a minimum, the following required documentation information:

- The date and time of visit. The date is given in MMDDCCYY format:
  Examples:
  02/10/2005; 8:00 a.m. – 11:15 a.m.
  11/24/2005; 10:30 a.m. – 3:15 p.m.
- The length of visit in decimal form.
  Example: a visit of three hours and 15 minutes is entered as 3.25 hours
- The services provided during the visit. If "other" is marked, a narrative must be provided.
- A statement of the participant's response to the services including any changes noted in the participant's condition.
- Any changes in the Plan of Care authorized by the referring physician or supervising registered nurse as the result of changes in the participant's condition.
- The participant's signature on the PCS record, unless the RMS determines that the individual is unable to sign.

3.12.2.3 Transfer To Another Provider

When the care of the participant is transferred between independent PCS providers, all participant records must be delivered to and held by the RMS

until the replacement provider assumes the case. When the participant leaves the PCS program, DHW retains the records of independent PCS providers as a part of the participant's closed case record. The provider maintains the original of the progress notes.

3.12.3 Physician Responsibilities

All PCS services must be provided under the order of a licensed physician or authorized provider. The physician or authorized provider must:

- Order all personal care services to be delivered by the PCS provider.
- Sign and date all orders and the participant's individual plan of care.
- Sign and record date of plan approval.
- Determine if the combination of personal care services along with other community resources are no longer sufficient to ensure the health or safety of the participant and recommend institutional placement of the participant.

The physician must provide DHW's RMS with the necessary medical information to establish the participant's medical eligibility for nursing facility (NF) placement.

3.12.4 Licensed Professional Nurse (RN) Responsibilities

An RN, who is not functioning as the PCS provider, is responsible for supervising the delivery of personal care services to the participant. The supervising RN may be an employee or contractor of a PCS agency or an independent contractor. The supervisory nurse must:

- Develop a PCS Plan of Care and have it approved by the attending physician.
- Supervise the treatment given by the PCS provider by reviewing the participant's PCS record maintained by the provider.
- Re-evaluate the PCS Plan of Care at least annually and as needed, and obtain physician approval on all changes.
- Notify the physician immediately of any significant changes in the participant's physical condition or response to the service delivery.
- Evaluate changes of condition when requested by the PCS provider, case manager, or participant through on-site visits. Provide a supervisory visit at least every 90 days or as specified in the individual support plan and plan of care.

***NOTE**:* Employees and contracted RN Supervisor for PCS organizations may refer to the *Idaho Medicaid Provider Handbook for Nursing Services* for more information.

The RN must submit documentation of initial assessment and the PCS plan of care to the RMS to receive authorization prior to submitting a claim for the service. Additional information may also be required by the RMS as necessary.

The supervising nurse may delegate to the PCS Provider such functions as assistance with medications.

3.12.5 PCS Plan of Care

All PCS services are based on an individual support plan and a PCS plan of care. The supervisory nurse is responsible for writing the PCS plan of care based on:

- The physician's evaluation and orders
- The nurse's assessment and observation of the participant
- Information elicited from the participant

A copy of the most current PCS plan of care must be kept in the participant's home. The plan must include all aspects of personal care necessary to be performed by the PCS provider, including the amount, type, and frequency of such services. Services performed, which are not contained in the Department approved PCS plan of care, are not eligible for Medicaid payments. Failure to follow the PCS plan of care may result in recoupment, loss of provider status for Idaho Medicaid, and/or other action as deemed necessary by DHW.

3.12.6 Functional Assessment/Individual Support Plan

The Functional Assessment/Individual Support Plan (HW0614) is in two parts. The first three pages of the HW0614 contain the medical and social data to be used in helping to identify the participant's social and medical status, and living situation. **To ensure confidentiality**, these pages must kept in the participant's file in the Regional Medicaid Services unit. Page four through nine of the HW0614 is the individual support plan. A copy of the pages must be maintained in the home for use by the PCS provider. All pages of the Functional Assessment/Individual Support Plan form must include the participant's name and Medicaid ID number.

After the Functional Assessment/Individual Support Plan is completed, the RN supervisor:

- develops a PCS Plan of Care
- recommends the number of PCS hours required.
- completes any other forms needed
- obtains the participant's or representative's signature on the self-declaration on the last page of the form
- obtains the attending physician's signature as required.
- delivers the packet to the RMS for review

The RN supervisor bills for Participant Evaluation and Individual Support Plan development for this service.

After the RMS approves the plan for PCS and a PCS provider is selected, the RN supervisor reviews the PCS Plan of Care with the PCS provider and has the provider sign the plan of care. The RN supervisor bills Medicaid for a RN supervisor visit for this service.

3.12.6.1 Personal Care Services Plan of Care - Physician Approval

The physician must sign, date, and approve the PCS plan of care. The signed plan must be submitted and approved by the RMS prior to initiation of the services by the PCS provider.

3.12.6.2 Individual Support Plan/Personal Care Service Plan of Care Update

The individual support plan/personal care service plan of care must be revised and updated based upon treatment results or a participant's changing needs as necessary, or at least annually. Services performed, which are not contained in the individual support plan, and PCS Plan of Care are not covered.

3.12.7 Payment

The PCS provider and the supervising RN are paid a fee-for-service basis as established by DHW. The PCS provider and supervising RN must submit separate claims for payment for each participant served.

PCS provider payments are limited to the services on the PCS plan of care on file with the RMS. All PCS plans of care must be approved by the RMS prior to claims payment. The supervising nurse submits the PCS plan of care directly to the RMS. The prior authorization number must be included on the claim or the services will be denied.

Non-medical transportation, such as transportation to the grocery store, is not reimbursable to the PCS provider unless approved under the HCBS Waiver. Medical transportation, such as to a physician's office, may be covered under the medical transportation section of the Medicaid program. A separate provider number for transportation services must be obtained by PCS, residential habilitation, day rehabilitation, attendant care, respite, and other waiver service providers. A transportation provider application can be obtained from the Medicaid Transportation Unit at (208) 334-4990 or (800) 296-0509.

3.12.8 Diagnosis Code

Enter the ICD-9-CM code V604 - "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS 1500 claim form or in the appropriate field of the electronic claim.

3.12.9 Place of Service Codes

PCS services may only be provided in a participant's personal residence. Use place of service code **12** to indicate the participant's residence.

Enter this information in field 24B on the CMS 1500 claim form or in the appropriate field of the electronic claim.

The following are specifically excluded as personal residences:

- Licensed skilled nursing facilities (SNFs), intermediate care facilities (ICFs), or hospitals
- Licensed intermediate care facilities for the mentally retarded (ICF/MR).
- Intensive treatment facility for children as describe in Department Rules at IDAPHA 16.06.01.487
- A home receiving payment for certified foster care, professional foster care, or group foster care for children.
- A home receiving payment for certified foster care, professional foster care, or group foster care for children.

See **Section 3.2.5** for more on billing instructions.

3.12.10 Procedure Codes

All claims must use one of the following five-digit HCPCS procedure codes when billing personal care services. Enter this information in field 24D on the CMS 1500 or in the appropriate field of the electronic claim.

3.12.10.1 Billing Restrictions

Hourly procedure codes cannot be billed on the same date of service as daily procedure codes.

Service	HCPCS Code	Description
Supervisory RN Codes		
Participant Evaluation and Plan of Care Development — Agency	G9002	*Coordinated Care Fee Maintenance Rate.* This code is to be used for the initial visit and annually for the re-evaluation. Prior authorization from RMS is required each time this procedure code is used. If additional evaluations are necessary, obtain prior authorization from the RMS. 1 unit = 1 visit The "date of service" for this code is the date that the individual support plan and PCS Plan of Care is completed, including the physician's approval.
Supervising Visit — Agency - RN	T1001	*Nursing Assessment/Evaluation* The frequency of the supervising visits must be included in RMS-approved Functional Assessment/Individual Support Plan. If additional or emergency visits in excess of the approved number are required, they must be prior authorized by the RMS. 1 unit = 1 visit

Service	HCPCS Code	Description
Agency PCS Providers		
Agency PCS Provider	T1019	*Personal Care Services, per 15 minutes, not for inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used* *to identify services provided by home health aide or certified nurse).* A maximum of 32 units (8 hours) may be billed using this code in any 24-hour period. 1 unit = 15 minutes
Agency PCS – One participant – Daily Care	S5145 U3 modifier required	*Therapeutic Foster Care, child, per diem* 1 unit = 1 day
Agency PCS – Two participants – 24 hour care	S5145 U3 and HQ modifiers required	*Therapeutic Foster Care, child, per diem* 1 unit = 1 day
TBI - Personal Care Services - Agency	S5125 U3 modifier required	*Attendant Care Services; per 15 minutes* 1 unit = 15 minutes Agency Providers, limited to 6 hrs/day
TBI - Personal Care Services – RN Supervising Visit	T1001 U3 modifier required	*Nursing Assessment Evaluation* RN Supervising visit 1 unit = 1 visit
TBI - Personal Care Services – Plan Development	G9002 U3 modifier required	*Coordinated Care Fee, Maintenance Rate* Agency Evaluation/Plan Development (one time per year)

3.13 Personal Emergency Response System Services

3.13.1 Service Description For DD Waiver, ISSH Waiver and TBI Waiver

Personal Emergency Response Systems (PERS) are provided to monitor the participant's safety and/or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who:

- Rent or own their home
- Are alone for significant parts of the day
- Have no regular caretaker for extended periods of time
- Would otherwise require extensive routine supervision

Note: Provider responsibilities, payment information, and diagnosis, place of service and procedure codes can be found in Section 3 of the *Idaho Medicaid Provider Handbook* for Medical Vendor providers.

3.13.2 Provider Qualifications

Providers of PERS must demonstrate that the devices installed in a participant's home meet Federal Communications Commission Underwriter's Laboratory, or equivalent standards.

Providers must be enrolled as medical vendors in the Idaho Medicaid Program and be able to provide, install, and maintain the necessary equipment in accordance with Federal Communications Commission Underwriter's Laboratory, or equivalent standards.

3.13.3 Procedure Codes

All claims must use one of the following five-digit HCPCS procedure codes when billing Personal Emergency Response System services. Enter this information in field 24D on the CMS 1500 claim form or in the appropriate field of the electronic claim.

3.13.3.1 TBI Waiver

Service	HCPCS Code	Description
TBI Waiver		
Personal Emergency Response System – Installation Fee	S5160 U3 modifier required	*Emergency response system; installation and testing*
Personal Emergency Response System – Monthly Rate	S5161 U3 modifier required	*Emergency response system; service fee per month (excludes installation and testing)*

3.13.3.2 DD/ISSH Waivers

Service	HCPCS Code	Description
DD/ISSH Waiver		
Personal Emergency Response System – Installation Fee	S5160 U8 modifier required	*Emergency response system; installation and testing*
Personal Emergency Response System – Monthly Rate	S5161 U8 modifier required	*Emergency response system; service fee per month (excludes installation and testing)*

3.14 Residential Habilitation Services

3.14.1 Service Description For DD Waiver, ISSH, Waiver and TBI Waiver

Residential habilitation (RES/HAB) services consist of an integrated array of individually tailored services that assist eligible participants in living successfully in their own homes, apartments, with their family, or in Certified Family Homes. Components of residential habilitation include skills training, personal assistance, and habilitation as listed in 16.03.09.143.01 for DD/ISSH Waivers and 16.03.09.769-771.01 for TBI Waiver and for all waivers under IDAPA 16.04.17, *Rules Governing Residential Habilitation Agencies*.

3.14.1.1 Personal Assistance Services

Personal assistance services support the participant in daily living activities, household tasks, and other routine activities the participant or primary caregivers are unable to accomplish.

3.14.1.2 Skills Training

Skills training involves teaching participants, family members, substitute caregivers, or a participant's roommates or neighbors to perform activities to enhance participant independence and to carry out or reinforce habilitation training. Skills training is provided to encourage and accelerate development in independent daily living skills, such as housekeeping, meal preparation, dressing and personal hygiene, taking medication, money management, socialization, mobility, and other therapeutic programs.

3.14.1.3 Habilitation Services

Habilitation services are aimed at assisting the participant to acquire, retain or improve his/her ability to reside as independently as possible in the community and maintain the family unity, if appropriate. Habilitation services include training in one (1) or more of the following areas:

- personal direction
- money management
- daily living skills
- socialization
- mobility
- behavior shaping and management

3.14.2 Supported Living

Supported living is a philosophy. For the purpose of these waivers, it is living with support and is included under the definition of residential habilitation.

Supported living is defined as one, two, or three participants living in their own home or apartment who require staff assistance, or one or two participants who live in the home of a non-paid family member and require staff assistance.

The home is defined to be owned or rented by the participant(s) when the mortgage, lease, or rental agreement is held by the participant(s) with supporting documentation of such. When two or three participants share a home or apartment, the staff may also be shared.

3.14.3 Certified Family Home

A Certified Family Home (CFH) is defined in IDAPA 16.03.19:

> A CFH may have a waiver approved by the Regional Medicaid Services Unit allowing service provision to 3-4 residents if certified by the Department for 3-4 persons. These providers are reimbursed to deliver at least one component: habilitation; personal assistance; or skills training that is defined within residential habilitation as outlined on the participant's plan of service.

3.14.4 Program Coordination

Program coordination is a function under residential habilitation. Program Coordination is defined as development, implementation, coordination, and evaluation of personal assistance, habilitation, and skills training provided for the participant as components of residential habilitation developed by a qualified mental retardation professional (QMRP)and delivered by a residential habilitation provider. Agencies providing oversight of residential habilitation in a certified family home or supported living environment must employ a program coordinator to provide this direct service for any participant who needs and desires residential habilitation.

Program coordinators must have the following qualifications:

- Education and experience to meet the criteria established for qualifying as a QMRP for DD and ISSH Waiver participants
- Demonstrate experience in writing skills-training programs
- Have skills in individualized strategy development and implementation to assist the participant in meeting wants and needs within the scope of Residential Habilitation

Billable activities include the following:

- Face to face contact with provider and/or participant regarding provision of Residential Habilitation
- Implementation plan development
- Evaluation, analysis, and/or revision of implementation plans
- Phone contacts specific to residential habilitation services identified on the ISP
- Attendance at participant meetings specific to residential habilitation services identified on the ISP.
- Emergency contact specific to residential habilitation services identified on the ISP.

3.14.5 Provider Qualifications

Residential habilitation must be provided by an agency certified by DHW as a residential habilitation services provider under *Rules Governing Residential Habilitation Agencies*, IDAPA 16.04.17, or by an independent Residential Habilitation provider who affiliates with a residential habilitation agency for

oversight, training and quality assurance. Residential Habilitation agencies must be capable of supervising the direct services provided.

Residential Habilitation providers who provide direct services to DD, ISSH, and TBI participants must meet the following requirements:

- Be at least 18 years of age
- Have a high school diploma or GED, or demonstrate the ability to provide services according to an ISP
- Have current CPR and first aid certifications
- Be free from communicable diseases
- Pass a criminal background check
- Have documentation of universal precautions training
- Participate in an orientation program provided by the agency prior to performing services including the purpose and philosophy of services, developmental disability, and human development, service rules, policies and procedures, proper conduct in relating to participants, and handling of confidential and emergency situations that involve the participant
- Have appropriate certification or licensure, if required, to perform tasks that require certification or licensure
- TBI Waiver only – have taken a Traumatic Brain Injury training course approved by the Department

3.14.6 Provider Responsibilities

3.14.6.1 Training

The provider agency is responsible for training the direct service provider in general education areas of developmental disability for DD Waiver/ISSH waiver and traumatic brain injury for TBI Waiver. The provider agency must provide supervision to meet the participant's needs.

A program coordinator must develop skill-training programs for TBI Waiver participants. A qualified mental retardation professional (QMRP) with demonstrated experience in writing skill training programs must develop skill-training programs for DD/ISSH Waiver participants. The program coordinator and/or QMRP is employed by the Residential Habilitation Agency.

Additional training requirements for direct service providers include at a minimum:

- Instructional technology
- Behavior technology
- Feeding
- Communication/sign language
- Mobility
- Assistance with the administration of medications
- Activities of daily living

- Body mechanics and lifting techniques
- Housekeeping techniques, and maintenance of a clean, safe, and healthy environment

3.14.6.2 Certified Family Home Provider Affiliation for DD and ISSH Waiver

Certified Family Home providers must be affiliated with a Residential Habilitation (RES/HAB) agency. They receive oversight, training, and quality assurance from the RES/HAB agency. A fee is paid to RES/HAB agencies for these services for CFH providers affiliating with the agency.

Agencies must maintain adequate documentation to support the date, times, amounts, and types (including contents) of training, oversight, and quality assurance services provided. This documentation includes telephone contacts and direct contacts with both the provider and participant.

3.14.6.3 Record Keeping

A RES/HAB provider must maintain a standardized residential habilitation service record for each participant receiving RES/HAB services. RES/HAB agency QMRP program coordinators are responsible for establishing a standardized format for record keeping that includes all required information.

A copy of the record is maintained in the participant's home, unless RMS authorizes another site. After every visit, document the following information:

- The date and time of visit. The date is given in MMDDCCYY format:
  Examples:
  02/10/2005; 8:00 a.m. - 11:15 a.m.
  11/24/2005; 10:30 a.m. – 3:15 p.m.
- The length of visit in decimal form. Example:
  a visit of three hours and 15 minutes is entered as 3.25 hours
- A statement of the participant's response to the services including any changes noted in the participant's condition
- Any changes in the support plan authorized by the RMS as a result of changes in the participant's condition or skills level
- The participant's signature on the service record, unless the RMS determines the participant is unable to sign

3.14.6.4 Records Maintenance

To provide continuity of services, when a participant moves, selects a different provider, or changes service coordinators, all of the foregoing participant records will be delivered to and held by the RMS until a new service coordinator or case manager for TBI Waiver participants assumes responsibility.

When a participant no longer is involved in the waiver services program, copies of all the records are retained by the RMS as part of the participant's closed record. Provider agencies must retain participant records for those to whom they provide services for five years following the last date of service.

3.14.6.5 Change in Participant Status

It is the responsibility of the RES/HAB provider to notify the plan monitor for DD and ISSH Waiver participants or the case manager for TBI Waiver participants when there is a significant change in the participant's circumstances including accident, injuries, and health related activities.

3.14.6.6 Change of Provider Information

If the provider has a change of name, address, or telephone number, immediately notify EDS in writing. Indicating updated provider information on a claim form is not acceptable and the appropriate changes cannot be made.

Send corrections to:

EDS
Provider Enrollment
P.O. Box 23
Boise, ID 83707

3.14.7 Payment

Medicaid reimburses residential habilitation services on a fee-for-service basis.

3.14.8 Diagnosis Code

Enter the ICD-9-CM code **V604** — "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS 1500 claim form.

3.14.9 Place of Service Codes

RES/HAB services can only be billed for the following places of service:

12 — Home (CFH and home of participant)

99 — Other place of service (Community)

Enter this information in field 24B on the CMS 1500 claim form or in the appropriate field of the electronic claim.

3.14.10 Procedure Codes

Bill all RES/HAB claims using one of the following five-digit HCPCS procedure codes. Enter this information in field 24D on the CMS 1500 or in the appropriate field of the electronic claim.

3.14.10.1 Billing Restrictions

Hourly procedure codes cannot be billed on the same date of service as daily procedure codes.

3.14.10.2 Supported Living - Agency ISSH/DD Waiver

Service	HCPCS Code	Description
Individual Supported Living Services- individual or group living arrangement 1-3 participants	H2015 U8 modifier required	*Comprehensive Community Support Services; per 15 minutes* (24-hour/day unavailable under hourly services) for participants who live in their own home or apartment or live with a non-paid caregiver. This code requires prior authorization. 1 unit = 15 minutes
Group Supported Living Services - agency Two or Three Participants	H2015 U8 and HQ modifier required	*Comprehensive Community Support Services; per 15 minutes.* Supported living for two (2) or three (3) participants who live in their own home or apartment or live with a non-paid caregiver. This code requires prior authorization 1 unit = 15 minutes 24 hour/day unavailable under hourly serviced
Daily Supported Living Services High Support: Participants must meet the SIB-R Support levels of Pervasive or Extensive Evaluation is case by case using the intense support criteria	H2022	*Community Based Services, per diem*. Blended staff
Daily Supported Living Services Intense Support : Participants require intense one-on-one supports. Evaluation is case by case using the intense support criteria	H2016	*Comprehensive Community Support Services, per diem* 1:1 staff 24 hours/day supported living service

3.14.10.3 Certified Family Home - Agency Affiliation Fee

Service	HCPCS Code	Description
Agency - Certified Family Home Affiliation Fee DD & ISSH Waivers	0919B	*Agency - Certified Family Home Affiliation Fee* 1 unit = 1 day. Limited to 6 hrs. 15 min per day

3.14.10.4 Certified Family Home – Independent

Service	HCPCS Code	Description
Certified Family Home –Daily 1 to 2 Participants	S5140 U8 or U2 modifier required	*Foster Care - Adult; per diem* 1 unit = 1 day • Use U8 modifier if resident is on the DD/ISSH waiver • Use U2 modifier if resident is on the Aged & Disabled Waiver Refer the reader to the A&D section of the handbook (See Information Release #2003-94).

3.14.10.5 TBI Supported Living Codes

Service	HCPCS Code	Description
Supported Living - Agency Two Participants TBI Waiver	H2015 U3 and HQ modifiers required	*Comprehensive Community Support Services, per 15 minutes.* Supported living for two (2) participants who live in their own home/apartment or with a non-paid caregiver. 1 unit = 15 minutes
Supported Living - Agency One Participant TBI Waiver	H2015 U3 modifier required	*Comprehensive Community Support Service, per 15 minutes* Supported living for one participant who lives in his/her own home/apartment or with a non-paid caregiver. 1 unit = 15 minutes
Independent Residential Rehabilitation Program Coordinator	0930T	*Independent Residential Habilitation Program Coordinator* 1 unit = 15 minutes Limited to 27 units per month **May only be billed if there is not an agency available in the participant's geographic location.** This code remains unchanged.
Certified Family Home - Agency One provider to two participants or two providers to one or two participants	S5140 U3 modifier required	*Foster Care, adult; per diem* 1 unit = 1 day
TBI Daily Rate (Bundled) One Provider, One or Two Participants; or Two Providers with Two Participants	H2016 U3 Modifier Required	*Comprehensive Community Support Services, per diem* 1 unit = 1 day (Bundled Care) This code is subject to FICA and State withholding by DHW on behalf of the participant.

3.15 Respite Care Services

3.15.1 Service Description for DD Waiver, ISSH Waiver, and TBI Waiver

Respite care services provided under the TBI waiver are short-term services provided in the home of either the participant or respite provider, to relieve the participant's family or the other primary unpaid caregiver's from daily stress and care demands.

Respite care services provided under the DD and ISSH waivers are services provided on a short-term basis because of the absence of persons normally providing non-paid care. These services may be provided in locations identified on the ISP.

While receiving respite care services, the participant **cannot** receive other duplicative waiver services. No room and board payment may be made as part of respite services. Respite care services are limited to participants who reside with non-paid caregivers.

3.15.2 Provider Qualifications

Providers of respite care services must meet the following minimum qualifications:

- Meet qualifications prescribed for the type of services to be rendered, for instance (RES/HAB) providers, or must be an individual selected by the waiver participant and/or the family or guardian. For TBI Waiver the person must be an employee of an agency.
- Have received care-giving instructions about the needs of the person for whom the service will be provided.
- Demonstrate the ability to provide services according to an Individual Support Plan (ISP).
- Have good communication and interpersonal skills and the ability to deal effectively, assertively, and cooperatively with a variety of people.
- Be willing to accept training and supervision by a provider agency or primary caregiver of services.
- Be free of communicable diseases.
- For TBI Waiver only: have taken a traumatic brain injury training course approved by the Department.

3.15.3 Payment

Medicaid reimburses waiver services on a fee-for-service basis. All Respite Care must be authorized by the RMS for the TBI, DD and ISSH waiver participant prior to payment.

3.15.4 Diagnosis Codes

Enter the ICD-9-CM code V604- "No other household member able to render care", for the primary diagnosis in field 21 on the CMS 1500 claim form or the appropriate field of the electronic claim.

3.15.5 Place of Service Codes

Respite care services can only be in the following places of service:

12 — Home (CFH)

99 — Other place of service (Community)

Enter this information in field 24B on the CMS 1500,claim form or in the appropriate field on the electronic claim.

3.15.6 Procedure Codes

Use one of the following five-digit HCPCS procedure codes when billing respite care services. Enter this information in field 24D on the CMS 1500, claim form or in the appropriate field on the electronic claim.

3.15.6.1 TBI Waiver

Service	HCPCS Code	Description
TBI Waiver		
Respite Care Services	T1005 U3 modifier required	*Respite Care Services, up to 15 minutes* 1 unit = 15 minutes Maximum of 6.75 hours per day or 27 units.

3.15.6.2 DD and ISSH Waivers

Service	HCPCS Code	Description
DD/ISSH Waiver		
Respite-Hourly	T1005 U8 modifier required	*Respite Care Services, up to 15 minutes* 1 unit = 15 minutes. Maximum of 6 hours per day or 24 units.
Respite-Daily	S9125 U8 modifier required	*Respite Care, In the Home, per diem* 1 unit = 1 day

3.16 Specialized Medical Equipment and Supplies Services

3.16.1 Service Description for DD Waiver, ISSH Waiver, and TBI Waiver

Specialized medical equipment and supplies include devices, controls, or appliances, specified in the ISP. The equipment and supplies must enhance the participants' daily living, and enable them to control and communicate within their environment. This also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the State Plan.

Items covered under DD/ISSH/TBI Waiver are in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items that are of no direct medical, adaptive, or remedial benefit to the participant. All items must meet applicable standards of manufacture, design, and installation, including Underwriter's Laboratory, Federal Drug Administration (FDA), and Federal Communication Commission (FCC) standards. Items available under the Medicaid program may only be billed by a medical vendor provider.

Note: Provider responsibilities, payment information, and diagnosis, place of service and procedure codes can be found in Section 3 of the *Idaho Medicaid Provider Handbook* for Durable Medical Equipment providers.

3.16.2 Provider Qualifications

Providers of Specialized Medical Equipment and supplies purchased under this service must:

- Be an authorized dealer of equipment that meets Underwriters Laboratory, Federal Drug Administration, or Federal Communication Commission standards when applicable
- Must provide the specific product when applicable (i.e. medical supply businesses or organizations that specialize in the design of the equipment)

Specialized Medical Equipment items over $500.00 require three competitive bids.

3.16.3 Place of Service Codes

Specialized Medical Equipment can only be provided in the following places of service:

11 - Office

12 - Home

3.16.4 Procedure Codes

Use the following five-digit HCPCS procedure codes when billing Specialized Medical Equipment. Enter this information in field 24D on the CMS 1500 claim form or in the appropriate field on the electronic claim form.

3.16.4.1 TBI Waiver

Service	HCPCS Code	Description
TBI Waiver		
Specialized Medical Equipment	E1399 U3 modifier required	*Durable Medical Equipment, Miscellaneous*

3.16.4.2 DD and ISSH Waivers

Service	HCPCS Code	Description
DD/ISSH Waiver		
Specialized Medical Equipment	E1399 U8 modifier required	*Durable Medical Equipment, Miscellaneous*

3.17 Supported Employment Services

3.17.1 Service Description For DD Waiver, ISSH Waiver, and TBI Waiver

Supported employment is competitive work in an integrated work setting for participants with the most severe disabilities for whom competitive employment has not traditionally occurred. Supported employment is also available for participants when competitive employment is interrupted or intermittent as a result of a severe disability. It assists participants who, because of the nature and severity of their disability, need intensive supported employment services or extended services in order to perform such work.

Supported employment does not include services provided by the Idaho Division of Vocational Rehabilitation (IDVR) such as evaluation, work adjustment, and job site selection.

3.17.2 Provider Qualifications

Supported employment services must be provided by an agency that is capable of:

- Supervising the direct service
- Meeting accreditation standards of the Commission on Accreditation of Rehabilitation Facilities or Rehabilitation Services Accreditation System, Accreditation Council, or other comparable standard
- Meeting State requirements to be a DHW-approved provider
- For TBI Waiver only: have taken a Traumatic Brain Injury training course approved by the RMS

3.17.3 Provider Responsibilities

The provider is responsible for supported employment services, including long term maintenance or job coaching to support the participant at work.

3.17.4 Payment

Medicaid reimburses DD, TBI, and ISSH Waiver services on a fee-for-service basis.

3.17.5 Diagnosis Codes

Enter the ICD-9-CM code V604-“No other Household member able to render care”, for the primary diagnosis in field 21 on the CMS 1500 claim form or the appropriate field of the electronic claim.

3.17.6 Place of Service Code

Supported employment services can only be billed in the following place of service:

99 – Other place of service (Community)

Enter this information in field 24B on the CMS 1500 claim form or in the appropriate field of the electronic claim.

3.17.7 Procedure Codes

Use the following five-digit HCPCS procedure code when billing supported employment services. Enter this information in field 24D on the CMS 1500 claim form or in the appropriate field on electronic billing software.

3.17.7.1 DD/ISSH Waiver

Service	HCPCS Code	Description
DD & ISSH Waiver		
Supported Employment	H2023 U8 modifier required	*Supported Employment, per 15 minutes* The maximum allowable units per week are 160. 1 unit = 15 minutes

3.17.7.2 TBI Waiver

Service	HCPCS Code	Description
TBI Waiver/		
Supported Employment	H2023 U3 modifier required	*Supported Employment, per 15 minutes* Maximum allowable – 160 units per week . 1 unit = 15 minutes

3.18 Claim Billing

3.18.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the date of service.

3.18.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

In addition to new HIPAA-required fields, the changes listed in Guidelines for Electronic Claims are effective October 18, 2003.

3.18.2.1 Guidelines for Electronic Claims

See **Section 2** for more information on electronic billing.

Detail lines
Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837 Professional claims.

Referral number
A referral number is required on an electronic HIPAA 837 Professional claim when a participant is referred by another provider. Use the referring providers' Medicaid provider number, unless the participant is a Healthy Connections participant. For Healthy Connections participants, enter the provider's Healthy Connections referral number.

Prior authorization (PA) numbers
Idaho Medicaid allows more than one prior authorization number on an electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

Modifiers
Up to **4** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

Diagnosis codes
Idaho Medicaid allows up to **8** diagnosis codes on an electronic HIPAA 837 Professional claim.

Electronic crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.18.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms (formerly known as the HCFA 1500) to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

The CMS-1500 claim form can be used without changes for dates in the year 2000 and beyond. All dates must include the month, day, century, and year.

Example: July 4, 2005 is entered as 07/04/2005

3.18.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed.
- Do not use staples or paperclips for attachments. Stack them behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.18.3.2 Where To Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.18.3.3 Completing Specific Fields on the Paper Claim Form

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit participant ID number exactly as it appears on the plastic participant ID card.

Field	Field Name	Use	Directions
2	Patient's Name	Required	Enter the participant's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field 11d is marked YES.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the participant's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections participant. Enter the referring physician's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connection participant. Enter the referring physician's Medicaid provider number. For Healthy Connections participants, enter the provider's Healthy Connections referral number.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	Enter the prior authorization number from DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MTU.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, year). **Example:** November 24, 2002 becomes 11242002 with no spaces and no slashes.

Field	Field Name	Use	Directions
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.
24F	Charges	Required	Enter your usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24I	EMG	Desired	If the services performed are related to an emergency, mark this field with an **X**.
24K	Reserved for Local Use	Required if applicable	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information.
33	Provider Name and Address	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	GRP — Provider Number	Required	Enter your nine-digit Medicaid provider number.

3.18.3.4 Sample Paper Claim Form

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500